STATEMENT ON

MEDICARE PROVIDER SERVICE NETWORKS

FOR THE

AMERICAN ASSOCIATION OF HEALTH PLANS

BY

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I. Introduction

Mr. Chairman and members of the Subcommittee, I am Thomas R. Sobocinski, President and CEO of Physicians Plus Insurance Corporation, in Madison, Wisconsin. Physicians Plus serves more than 100,000 members in south-central and southeastern Wisconsin. I appreciate the opportunity to testify today about provider sponsored organizations (PSOs).

Physicians Plus was licensed as an HMO in 1987 and, until May of last year, was entirely owned and governed by providers -- by Physicians Plus Medical Group and Meriter Hospital. Today, providers continue to hold a two-thirds ownership and governance stake. We believe that Physicians Plus is an example of the right way for providers to take on health care risk. By forming Physicians Plus HMO, the Physicians Plus Medical Group and Meriter Hospital entered the insurance business and became subject to the same licensing and financial solvency requirements applicable to any other HMO insurer in Wisconsin.

I am testifying today on behalf of the American Association of Health Plans (AAHP). AAHP represents approximately 1,000 health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other network-based health plans throughout the United States. Together AAHP member plans provide care for more than 140 million Americans. Nearly 20 percent of AAHP's member plans are provider-owned.

The health care market has changed in the two years since Congress first considered the issue of PSOs. In today's market, an increasing number of provider-owned entities -- like Physicians Plus -- are performing the same functions as HMOs and are complying with the same regulatory requirements.

Some providers have urged Congress to pass legislation granting PSOs participating in the Medicare risk contracting program[1] exceptions to current law. While AAHP supports the expansion of choices for Medicare beneficiaries as a way to improve the current program, this expansion must be accompanied by safeguards for beneficiaries and the Medicare program -- by ensuring that all Medicare offerings meet consistent, national consumer protections. In addition, AAHP believes that entities performing the same functions -- in this case, providing health care to Medicare beneficiaries -- should be required to meet the same standards.

My comments today focus on the following specific areas:

- the rapid growth of provider sponsored organizations under current state licensure requirements for HMOs;

[1]The risk contracting program is a program established under section 1876 of the Social Security Act that authorizes Medicare to contract with health maintenance organizations (HMOs) and competitive medical plans (CMPs) to provide Medicare benefits to beneficiaries choosing to enroll in them. HMOs and CMPs with a Medicare risk contract (often called "risk contractors") are paid a fixed amount per member per month for providing all covered services. A CMP is an HMO that has not chosen to pursue designation as a "federally qualified HMO" under title XIII of the Public Health Service Act, but meets similar standards for Medicare. For the remainder of this testimony, we use the term "HMO" to refer to both HMOs and CMPs.

- current consumer protections and regulation of HMOs under the Medicare risk contracting program and their appropriateness for all contracting entities; and,
- the implications of current proposals for PSO participation in the Medicare program.

II. Growth of Provider-Sponsored Organizations

PSOs are growing rapidly in the marketplace under the existing state licensure and regulatory requirements for health plans. This growth makes it clear that, in contrast to the claims of PSO proponents, state and antitrust laws are not barriers to market entry. Physicians Plus stands as an example of a PSO that has succeeded in this environment for almost 10 years. Many other PSOs are new to the market. More than 300 provider-owned, regulated health plans now operate in 43 states. In addition to strong growth in the number of provider-owned HMOs and PPOs, enrollment growth among many of these plans has been increasing rapidly.

Modern Healthcare (June 17, 1996) reported that from 1994 to 1995, enrollment in the 10 largest provider-owned HMOs increased 16.7 percent, from 2.1 million to 2.4 million. For example, SelectCare, a provider-owned HMO located in Oregon, doubled its enrollment over the past three years to 151,000 while Paramount Health Care, a provider-owned HMO based in Ohio, increased its enrollment 187 percent over the past five years to 64,900. Examples like these underscore how well PSOs can prosper and compete under existing state laws.

In most states, this growth has been achieved by provider-sponsored organizations operating under a state HMO license. Thirteen states have enacted statutes or regulations specifically

governing PSOs or provider networks, and the existing standards in many other state laws governing health plans are compatible with efforts by provider groups to form managed care plans. Recognizing the need for consistent regulation, the National Association of Insurance Commissioners (NAIC) is currently developing a model standard for entities that perform similar activities -- regardless of the entity's governance, ownership or acronym.

Just as the vigorous growth among PSOs demonstrates that existing state licensure requirements have created a climate conducive to PSO development, it also demonstrates that current antitrust laws are compatible with PSO expansion. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have taken affirmative steps to foster the expansion of choices for health care consumers by promoting providers' and plans' understanding of the antitrust laws and their enforcement through timely issuance of advisory opinions. Further, the Department of Justice and the Federal Trade Commission last year issued revisions and clarifications to their antitrust policy guidelines on physician networks spelling out the types of situations in which providers can join forces and still comply with antitrust laws.

III. Current Regulation of the Medicare Risk Program

The current regulatory framework of the Medicare program was put into place to ensure that beneficiaries were provided adequate consumer protections. This framework has been developed based on extensive expertise, and has proven effective for beneficiaries, plans, and the Medicare program. It is important to remember that many provider-owned entities are new, and safeguards in current law may be particularly important to their long-term success. Indeed, we understand

that in its upcoming report to Congress, the Physician Payment Review Commission will recommend that the same set of core standards be applied to all Medicare plans.

Where established standards have not been applied to organizations participating in public programs, problems have occurred. For example, in Florida, when Medicaid officials did not require all prepaid contractors to meet the same standards as those applied to commercial HMOs, the program was plagued by marketing fraud, and many of these entities lacked the financial reserves to provide high-quality care. In response to these problems, Florida now requires all prepaid plans participating in the Medicaid program to meet the standards for HMO licensure.

Role of Federal and State Regulation for HMOs under Medicare**.** The current two-tiered state-federal regulatory scheme has proven effective in ensuring that Medicare beneficiaries -- no matter where they live -- receive promised benefits and services from viable entities.

In order to participate in Medicare today, HMOs must meet detailed federal standards on many aspects of their operations, including marketing, enrollment and disenrollment procedures, benefits, access to care, quality assurance programs, grievances and appeals, reporting and disclosure, solvency and other enrollee protections. These Medicare standards are designed to ensure that all organizations entering the Medicare program have the organizational structure and operational capacity to provide health care to Medicare beneficiaries.

HMOs participating in Medicare must also be state licensed. To be licensed, HMOs and other integrated delivery systems must meet comprehensive consumer protection standards established at the state level, including standards addressing areas such as quality and accessibility of services, member information, financial solvency, utilization review and grievance procedures. State licensure provides a level of local accountability to the federal regulatory standards.

States' expertise and infrastructure make state oversight of solvency an important foundation for federal oversight of plans contracting with the Medicare program. State solvency and capitalization standards are designed to ensure that health plans have the financial strength and stability to provide care to the patients they enroll. State capitalization standards are particularly important for new plans, because it is common for new organizations that provide as well as pay for health care services to sustain losses in their early years of operation. This is due in part to the fact that they must absorb the start-up costs of creating a delivery system and the infrastructure that supports it. Adequate solvency standards are particularly critical for plans serving Medicare beneficiaries because these beneficiaries use services more frequently and intensively than younger populations.

IV. Current Proposals Do Not Provide for Consistent Safeguards for Consumers

In contrast to the current Medicare regulatory framework, pending legislative proposals designed to permit PSOs to enter the program do not establish comparable standards among all organizations serving Medicare beneficiaries and do not provide comparable safeguards for Medicare enrollees. For example, HR 475, the Medicare Provider-Sponsored Organization Act

of 1997, introduced by Representatives Greenwood (R-PA) and Stenholm (D-TX), would allow PSOs to participate in the Medicare program under a different set of rules than current Medicare HMOs. The bill proposes relaxed standards, even though the PSOs would be paid the same way and perform the same functions as Medicare HMOs. Available reports indicate that the PSO portion of the Administration's proposal takes a similar approach. At this time, we would like to take the opportunity to comment on HR 475.

While AAHP strongly supports broader availability of health plan choices for beneficiaries, we believe that beneficiaries should have the assurance that all options available to them meet the same high standards. The existing framework of regulation of HMO Medicare contractors has proven to be a solid foundation for expansion of the choices available to Medicare beneficiaries. Unfortunately, we believe that many of the modifications and additions to current law proposed in HR 475 would weaken existing consumer protections. AAHP looks forward to working with the sponsors of the legislation to address the following areas of concern:

Definition of a PSO. AAHP is concerned that the PSO definition fails to ensure a sufficient degree of integration among providers who comprise the organization. Using the bill's definition of "affiliation," the bill would permit arrangements under which independent providers share risk but are not under any common control. For example, a hospital and physician group could form an agreement, accept capitation, and share risk. But no third, separate entity in control of the two independent entities would need to be established, nor would the two need to be financially

integrated. Such a loosely structured entity could easily disband -- leaving Medicare beneficiaries without promised care and potentially damaging efforts to expand beneficiaries' choice by undermining their confidence in the stability of the plans available to serve them.

Preemption, Postponement, and Waiver of State Licensure. HR 475 would not require a PSO contracting with Medicare to be state licensed until January 1, 2002. At that time, state licensure would be required, but only in those states with licensure requirements equivalent to the federal standards and state solvency requirements identical to the federal standards. This provision raises the possibility of a permanent exemption from state licensing and consumer protection standards, if states failed to change their standards -- in effect imposing federal standards on states that want to maintain regulatory oversight of health plans serving their residents. The bill makes it relatively easy for a PSO to have the state licensure requirement waived altogether -- even if the state initially disapproves the PSO's licensure application. This provision would permit the Secretary to grant a waiver if the state were found to have applied requirements that impose "unreasonable" barriers to market entry. By not specifying in statute what constitutes "unreasonable" barriers to market entry, the bill provides a great deal of latititude for the federal government to waive state law.

The importance of the role of the states in licensure and in enforcing solvency and other standards cannot be overstated. States have historically been responsible for such oversight and have the experience and infrastructure in place to continue this role. AAHP strongly supports continuation of the requirement that all Medicare risk contractors be state licensed and supports the states'

prominent role in developing and enforcing solvency and other licensure requirements.

Different Solvency and Insolvency Standards. HR 475 establishes different federal solvency requirements for PSOs that lack important elements of standards currently applied to Medicare risk contractors. AAHP strongly opposes weaker solvency standards for entities that perform the same functions and deliver the same services as other Medicare risk contractors. Provider groups have asserted that capital and solvency requirements should be lower for PSOs than for other risk contractors because if a PSO's funds are exhausted, the provider group can simply provide medical services without payment. However, beyond costs associated with the services delivered by their own providers, PSOs must pay for the cost of equipment, supplies, staff, and services -- such as nurses' salaries, hospital overhead and medical equipment -- that are essential to providing care. In addition, the complexity of the task of assuming responsibility for the financing and delivery of quality care argues strongly for ensuring that new entities have sufficient financial resources to succeed.

A critical protection omitted from PSO standards under HR 475 is the requirement that a plan must include in provider contracts a hold harmless provision. HMO contracts must have such a provision which requires providers to look only to the HMO for obligations that are the HMO's responsibility and prohibits them from billing beneficiaries for these costs.

Deemed Status for Quality Assurance. The legislation contains detailed quality standards that -- while largely consistent with current HMO quality monitoring and improvement requirements -- put into statute what previously have been regulatory initiatives. The danger in this degree of specificity in statute is that it will freeze quality accountability to present day standards. Quality improvement systems and performance measurements are rapidly evolving, and the current statutory framework provides necessary federal oversight authority while permitting Medicare contractors to keep pace with this evolution. Consequently, we do not believe that the changes proposed in the bill are beneficial. In addition, while it makes sense to "deem" a PSO that meets current law quality standards through private accreditation as having met the federal requirements, it does not make sense to exclude other risk contractors from being eligible for deemed status. The deemed status option should be available to all Medicare risk contractors .

AAHP supports the development of criteria in connection with waiving the 50/50 enrollment requirement for Medicare HMOs. While the criteria in the bill are too restrictive and would potentially interfere with progress on quality improvement, AAHP supports further efforts to develop such criteria.

Minimum Enrollment Exception. AAHP strongly opposes the provision in HR 475 which would provide an exception for PSOs from the current law minimum enrollment requirements for their first three contract years and which would reduce the minimum enrollment requirements thereafter. The current minimum enrollment requirement was designed primarily to promote financial stability of plans receiving capitation payments under the Medicare program and to

ensure that plans have a sufficient base over which to spread risk. Therefore, it makes sense to apply these requirements uniformly across all risk contractors. While we believe that the smaller population ban in rural areas justifies the rural exception in current law, all other organizations should meet the same minimum enrollment standard. AAHP supports uniform enrollment requirements for Medicare risk plans with a uniformly applied exception for rural areas and waivers during a plan's initial three years only if the plan demonstrates progress toward required levels.

V. Conclusion

Many PSOs are licensed entities performing the same functions as HMOs and other similar types of health plans. In examining legislation that modifies the existing, largely successful regulatory structure for the Medicare risk contracting program, AAHP urges Congress to ensure consistent application of consumer protections, including solvency requirements, to all contracting entities, including PSOs. A consistent approach to regulation will ensure that Medicare beneficiaries will have access to an increasing number of high-quality, affordable health care options into the next century.